IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

MEGAN C. IRWIN and THOMAS L. IRWIN, INDIVIDUALLY AND AS FATHER AND NEXT FRIEND OF MINOR CHILDREN M.1, M.2 AND T.1, Plaintiffs -VS- ECLECTIC DINING, INC., d/b/a ATLANTICA'S OLDE SALT HOUSE, Defendant	CA No. 13-10974-ADB Pages 1 - 92

JURY TRIAL - DAY THREE - PART TWO

BEFORE THE HONORABLE ALLISON D. BURROUGHS
UNITED STATES DISTRICT JUDGE

United States District Court
1 Courthouse Way, Courtroom 17
Boston, Massachusetts 02210
September 30, 2015, 1:29 p.m.

LEE A. MARZILLI
OFFICIAL COURT REPORTER
United States District Court
1 Courthouse Way, Room 7200
Boston, MA 02210
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A P P E A R A N C E S:

SCOTT E. CHARNAS, ESQ., Charnas Law Firm, P.C., 66 Long Wharf, Boston, Massachusetts, 02110, for the Plaintiffs.

JOHN F. X. LAWLER, ESQ. and HEATHER M. GAMACHE, ESQ., Prince Lobel Tye, LLP, 100 Cambridge Street, Boston, Massachusetts, appearing for the Defendant.

I N D E X

P R O C E E D I N G S

(Resumed, 1:29 p.m.)

THE CLERK: All rise.

(Jury enters the courtroom.)

THE CLERK: Court is in session. Please be seated.

THE COURT: Because of some of the travel difficulties with the witnesses, Mr. Lawler is going to begin his cross-examination of Dr. Hibbard. Then we'll have a short break, and then Mr. Charnas will do his direct examination of the next witness. And then Mr. Lawler will do his cross-examination of that witness, and then we will finish Dr. Hibbard's cross-examination, and we expect that both cross-examinations will proceed tomorrow. So two crosses and then a short break. Where we can, we try to accommodate the witnesses' schedules.

Mr. Lawler?

MR. LAWLER: Thank you, your Honor.

Good afternoon, ladies and gentlemen.

CROSS-EXAMINATION BY MR. LAWLER:

Q. Dr. Hibbard, my name is John Lawler. We met in New York a while back.

A. Yes, we did.

Q. Good afternoon. How are you?

A. Good, thanks.

Q. Now, right before the break, during your direct

examination, you used the phrase "a 100-pound umbrella." Is that correct?

A. That's correct.

Q. Okay. And that was your understanding of how much the umbrella weighed on the day that it struck Megan Irwin, right?

A. No. That was abstracted from her medical report in one or two places.

Q. Okay. But you believe today that the umbrella weighs 100 pounds, right?

A. It was the fact abstracted from the medical report.

Q. Okay. But you considered that fact, a 100-pound umbrella, in arriving at your conclusions, correct?

A. No. It represents, an umbrella is a weighted object falling at force. I have no idea how high it flew, I have no idea, but there is a force impacting her head. That meets the criteria for a traumatic blow to the head.

Q. Okay, and you believe that that force was a 100-pound umbrella; is that right?

A. No. She had a force that created altered mental status.

MR. LAWLER: Okay, may I approach the umbrella, your Honor?

THE COURT: Yes.

MR. LAWLER: Thank you.

Q. Would it surprise you, Doctor, to realize that the umbrella weighs 15 pounds? Would that surprise you?

A. Uhm, well, it's contrary to the medical documentation. It doesn't change what happened to the patient, however.

Q. Okay. Now, during direct examination, Doctor, you spoke briefly about your qualifications, your background, your education, et cetera, right?

A. That's correct.

Q. And I'm not sure if I heard it correctly. Did you say on direct examination that you have a doctorate in psychology?

A. That's correct.

Q. Okay. Do you have your expert report in front of you and your CV?

A. I have my CV.

Q. Is that Page 2 of your CV? Is it there?

(Witness examining document.)

A. "Education, Doctorate in Philosophy." That is the doctoral category for the psychology degree. It's under the Philosophy Department. It is a subdivision of the Philosophy Department.

Q. Okay. But what you have in front of you is a copy of your resume` or curriculum vitae, right?

A. That's correct.

Q. And under Education, from 1976 to 1984, it says "Doctorate in Philosophy, New York University, New York," correct?

A. That's the official title of the doctorate.

Q. All I'm asking you, Doctor, is what I just read, is that

correct?
A. That's correct.
Q. Thank you. Now, you were retained in this particular case by Attorney Charnas; is that correct?
A. That's correct.
Q. And when were you retained by Attorney Charnas?
A. Probably in January or February. I don't have the documentation of the specifics of it.
MR. LAWLER: May I approach, your Honor?
THE COURT: Yes.
Q. I'm showing you or I'm going to hand to you a revised bill, and I'm just going to walk back to my podium and I'll ask you some questions on that. Now, this is a bill to Attorney Charnas, and your name is at the bottom of it. It's a signature from you, Mary Hibbard, correct?
A. That's correct.
Q. And it essentially articulates the work that you did in reference to this particular case, right?
A. Correct.
Q. And it's safe to say that the work that you did in reference to preparing this particular report, the one that you were reading from, I think, during your direct examination, you charged $350 an hour, correct?
A. That is my fee per hour for my work, yes.
Q. Okay. So if you can just -- what I want to do is, I just

want to follow line by line the work that you did in the case, okay?

A. Correct.

Q. Okay, so the first entry is "Medical documentation review and abstraction." What's abstraction?

A. Highlighting the important components of a medical chart and then synthesizing it into a beginning semblance of a report of that area.

Q. Okay. And you performed that particular work from March 20, 2014, to April 22, 2014; is that correct?

A. That's correct.

Q. And the next entry is March 20, 2014, correct?

A. Correct.

Q. And that involved the clinical interview of the patient, right?

A. Correct.

Q. And in this case, it was Mrs. Irwin, right?

A. Correct.

Q. Two hours, and you charged $700 for that, right?

A. That's correct.

Q. Okay. And then the next entry on the bill -- and I know it's not in chronological order, but that's fine -- the next entry is "Clinical interview of husband," and that was done on April 2, 2014, right?

A. Correct.

Q. And there's an hour entry for that, right?
A. Correct.
Q. And the husband is Thomas Irwin, the husband of Mrs. Megan Irwin, correct?
A. Correct.
Q. And you conducted that interview over the telephone, right?
A. That's correct.
Q. And then the next entry says "Neuropsychological testing, day one, March 20," and that's for one hour, right?
A. Correct.
Q. So on the same day that you interviewed Mrs. Irwin, you also tested her for an hour as well, right?
A. Yes, I did.
Q. Okay. And then the next entry is "Neuropsychological testing, day two," and that's on March 26, 2014, correct?
A. Correct.
Q. And that's for three hours, right?
A. Correct.
Q. And the next entry is "Neuropsychological testing, day three." That's for three hours, and then that's on April 1, 2014, right?
A. Correct.
Q. And then "Scoring of data and preparation of appendix," that was done on April 15, 2014, and that took two hours,

right?
A. Correct.
Q. And then you prepared the report; is that correct?
A. That's correct.
Q. And the report, you have a copy in front of you, don't you?
A. Yes, I do.
Q. And that's dated April 24, 2014, correct?
A. Correct.
Q. And to prepare the report, that took you seven hours, right?
A. That's correct.
Q. And you charged for the preparation of the report $2,450, right?
A. Correct.
Q. And then also on April 23, 2014, you prepared the treatment recommendations that you talked about during direct examination, right?
A. That's correct.
Q. And that took an hour, right?
A. Correct.
Q. Now, the last entry on that is "Review of report/revisions with lawyer," right?
A. Correct.
Q. And that was done on April 24, 2014, right?

A. Correct.
Q. And you charged two hours for that, right?
A. Correct.
Q. $700, right?
A. Correct.
Q. And so what you did was, did you do the revisions -- when you say "attorney," is that Attorney Charnas?
A. Yes.
Q. Okay, so do you speak on the phone with Attorney Charnas while you're doing your revisions to the report, or do you meet with him?
A. No. It's usually on the phone.
Q. Okay. So it's safe to say that you prepared a report, and then you revised it based on your conversation with Attorney Charnas, correct?
A. Uhm --
Q. Either "yes" or "no," ma'am.
A. Yes.
Q. Okay. Now, do you have a copy for us to see of the report that existed before you revised the report with Attorney Charnas?
A. I do not have a copy with me.
Q. Could you get us a copy? You're going to testify tomorrow. Could you get us a copy?
A. I don't know if I can. I can see if I have one. I don't know.

Q. And you probably don't because you destroyed the earlier copies; isn't that correct?
A. No, that doesn't assume that. I just don't want to say "yes" or "no" if I don't know for sure if it's -- I don't have a file of it here is all I can say "no" to.
Q. Okay. Now, getting back to the fee schedule, and when I deposed you in New York City -- I think it was approximately maybe a year ago or so, a little bit longer -- you charged me $5,000 for that deposition, right?
A. That's correct.
Q. And for your trial testimony today, can you tell the ladies and gentlemen of the jury what you charge for your trial testimony?
A. $6,000.
Q. $6,000, does that include if you have to come back tomorrow too?
A. Yes.
Q. Okay, so $6,000 overall?
A. Correct.
Q. Now, you prepared the report, and what I want to do is, I want to go through the report with you.
THE COURT: Mr. Lawler, can I see you at the sidebar for one minute before you --
MR. LAWLER: Certainly.

SIDEBAR CONFERENCE:

THE COURT: Your next witness is in the courtroom. I just wanted to make sure you were okay with that before we start.

MR. LAWLER: No. I want him out. I'll ask him to leave. Thank you, your Honor.

(End of sidebar conference.)

BY MR. LAWLER:

Q. Now, Dr. Hibbard, I would like to talk a little bit about your report this afternoon. Could you please turn to the second page of your report. Actually, why don't we start at the beginning. Why don't we go back to the first page. And on the first page you state what records you have looked at in regard to this particular case before you completed the report, right?

A. That's correct.

Q. And it also tells us what tests you administered, correct?

A. That's correct.

Q. And on Page 1 and Page 2, you list a number of tests that were administered to Mrs. Irwin, correct?

A. That's correct.

Q. And a number of these tests Mrs. Irwin completes before you ever see her; is that correct?

A. A very limited number of tests are done, and those are self-report measures of how she's feeling.

Q. Right. So can you go down the list with me. I'm going to start at the first one. And when you say "self-report," that means the patient reports, right?
A. Typically, yes.
Q. Right. So, for instance, there might be a question that says, "Do you have a headache today?" and you either answer "yes" or "no," and that's the patient who answers that, right?
A. That's what self-report means, yes.
Q. Okay. So the first test, the Beck Depression Inventory-II, that is self-report, correct?
A. That is correct.
Q. The Beck Anxiety Inventory, that is self-report?
A. Correct.
Q. The Brain Injury Screening Questionnaire, that is self-report, correct?
A. Correct.
Q. The Minnesota Multiphasic Personality-2-Restructured Form, the MMPI-2-RF, that is self-report, correct?
A. Correct.
Q. Are there any other tests listed on those two pages that are self-report other than those ones that I just mentioned?
A. No.
Q. So essentially four of the eighteen tests are self-report, correct?
A. Might I qualify that the remaining tests on the list

are -- many say "select subtest," so it's not a test but a composite of tests.

Q. Understood, so one test may have a number of tests within it?

A. A large number.

Q. And it's safe to say that when you look at a self-report test, when you look at the results of the self-report, you believe what the patient is telling you, correct?

A. I think that's the principle of any interview of a professional with a patient: You do believe what they have to say at their face value.

Q. Right. So if I come in to you and you say to me, "Do I have a headache?" and I say "Yes," even though I feel great, I have no headache at all, if I tell you I have a headache, you say, "John Lawler has a headache," right?

A. No. In review of that self-report, when I saw that item, I'd say, "Tell me about your headache."

Q. Okay. And you're going to say to me, "How does it feel on a 0 to 10 range?" and I say, "It feels like a 6," and you write that down, right?

A. That is a self-report response, yes.

Q. And you believe what I say?

A. That's why there are tests of effort in this measure.

Q. Okay. Well, in regard to tests of effort -- and we're going to come back to this, but this is a point that you made

in direct examination -- you believe that Mrs. Irwin gave effort, full effort, right?
A. I do.
Q. Okay. Is it safe to say that when you were testing her and interviewing her, that she refused to turn off her iPhone?
A. Is it safe to say?
Q. Yes. Did she do that?
A. She -- she did not. She was -- this was part of her hypervigilance issue that I discussed earlier, that she couldn't -- she was petrified to leave her phone off.
Q. Okay, so --
A. -- for fear of the children getting hurt.
Q. But you certainly see people with their iPhones today, whether it's a voice message or more likely a text message, they can't be away from it for more than, you know, 30 seconds, right?
A. That's correct. Under certain tasks, I'd have her turn off her phone for brief periods of time, and then she'd turn it back on as soon as it was done to see if anything had happened.
Q. Okay, so maybe she wanted to complete some tasks quicker than she was supposed to then in order to get the phone back on?
A. I don't think that had anything to do with the speed at which she did tasks.
Q. Okay, let's go back to the report on Page 2. Now, in the

middle of that page it says that the reason for the referral is to assess Mrs. Irwin's current cognitive and effective functioning secondary to a traumatic brain injury occurring at the time of an accident on August 5, 2012, correct?

A. Correct.

Q. And when Mrs. Irwin comes in to see you on the date that you interview her, you assume that she's already suffered a brain injury, correct?

A. I've already read her medical report where it's replete with that diagnosis.

Q. Okay, so she's coming into the office, and you believe that she has a brain injury, and you want to test her?

A. No. My purpose is to validate whether she's had one or not.

Q. Okay. And Mrs. Irwin is aware when you start to talk to her that you have been retained by her lawyer in a lawsuit; is that right?

A. Always a question that I ask her: "Who sent you?" Yes.

Q. Okay. So before any answers that she provides to you, she knows that you have been retained by her lawyer in this lawsuit suing a defendant, correct?

A. That's correct.

Q. And after you get that information out to Mrs. Irwin in this particular case, you then take a history from her, correct?

A. I preface it with, "The important thing here is that you're honest and you leave no hidden anything in your history, to be honest and upfront."

Q. Okay. And, again -- I think you said it about five minutes ago -- the whole practice of psychology is that you take the patient's word for it, right?

A. It's the practice of many fields.

Q. Okay. I mean, but we're not in many fields right now, Doctor. We're in psychology. So you'd agree with me that that's the practice in psychology and that you practice that?

A. That is the gold standard, yes.

Q. And it's important for you to receive accurate information in order to make an accurate diagnosis, correct?

A. Yes.

Q. Okay. I know in the computer world, sometimes people use this term "garbage in, garbage out," right?

A. Yes.

Q. You've heard that before?

A. I'm familiar with that term.

Q. Okay, that means basically bad information leads to possibly a misdiagnosis or an improper diagnosis, right?

A. Yeah.

Q. Okay. So you start to question Mrs. Irwin about her background and how she feels, what she's able to do, what she's not able to do, et cetera, right?

A. Correct.
Q. And in regard to her background, look at under the "Self-Reported psychosocial and medical history pre-accident," in the third paragraph, do you see where it says, "She reported that she played lacrosse through her four years in college"? Do you see that?
A. That's correct.
Q. And she told you that, right?
A. Correct.
Q. Would you be surprised to learn that she only played one year of lacrosse in college and decided to quit because it was too competitive? Would that surprise you?
A. It would surprise me, but as somebody who works with individuals with TBI, I'd say that's good news, but it surprises me, but it doesn't change anything.
Q. Okay. And then you also decided you wanted to learn some history about Mrs. Irwin's family, right?
A. I routinely ask family history as part of my interview.
Q. Right. And it's important also -- it was important to you to find out about the educational background of Mrs. Irwin's parents and also her siblings, right?
A. That's correct.
Q. Okay. And do you see the last paragraph?
A. I do.
Q. Okay. And it says on the second sentence, "Her mother

holds a doctorate in education." Do you see that?
A. That's correct.
Q. And that was information that Mrs. Irwin relayed to you, right?
A. That is correct.
Q. Okay. Would you be surprised to hear that Mrs. Connolly, the mother of Mrs. Irwin, while she holds a master's degree in education, does not hold a doctorate in education, does not hold any doctorate? Would you be surprised to hear that?
A. It's the first time I'm hearing it, so I have to be surprised.
Q. Okay. And it's safe to say that in arriving at the premorbid functioning IQ for Mrs. Irwin, you took into account the education of her parents and her siblings, right?
A. Along with many other factors.
Q. Understood, along with many other factors, but that was one factor, right?
A. It's one of many, yes.
Q. Okay. And in fact you see two sentences down from the sentence you just read, it says, "Her father --" and "her father" means Mrs. Irwin's father who's Edward Connolly, correct?
A. Correct.
Q. "Her father holds nine master's degrees"? I read that correctly, right?

A. I questioned it. I said "Nine?" She said, "Yes, nine."
Q. Right, you actually questioned her in that situation because that information sounded unusual to you, right?
A. And she went with it, so this is her self-report.
Q. Right. Would you be surprised to learn that he only has -- I say only, that's good -- only has one master's degree?
A. It would be more logical, but this is her self-report.
Q. Okay. And then you go into her educational background, correct?
A. Correct.
Q. And you question her about her grades, right?
A. Correct.
Q. And you learned that she graduated from Catholic University in 2003, right?
A. Correct.
Q. And that her class ranking was 311 out of 365, right?
A. That's what she reported.
Q. That's the bottom 15 percent of the class, right?
A. Correct.
Q. Okay. Now, you also spoke to her husband, Thomas Irwin, correct?
A. That's correct.
Q. And you interviewed him over the phone, and then you incorporated that information into your report, correct?
A. That is correct.

Q. Okay, turn to Page 4. It's the middle of the report, and look Line 6, please. Do you see where it starts with Mister?
A. Yes.
Q. It says, "Mr. Irwin reports his relationship with his wife was enjoyable and romantic pre-injury. The couple routinely planned date nights and time spent alone. When asked about potential tension in the marriage pre-accident, Mr. Irwin reports that the tensions were typical of any new couple as they began to start a family." I read that correctly, right?
A. That was his report, correct.
Q. Okay, so that's what he told you, right?
A. That's correct.
Q. But you learned -- actually, you learned before you interviewed him that, really, there was a completely different story than what Mr. Irwin described, correct?
A. That is correct. Hence, when asked -- there's a question here about it -- when asked about potential tensions in the relationship, that was me asking about, are there any potential relationship issues? And this was his response.
Q. Right, and in fact his response is vastly different than the response of Mrs. Irwin, correct?
A. That's correct.
Q. Because Mrs. Irwin essentially told you that she was in a terrible marriage and that she wanted to get out of the marriage, correct?

A. I don't think she used quite those strong terms. Let me just see what I said on it.

(Witness examining document.)

A. I did not use those strong terms. I said her marriage had interpersonal difficulties. "She attributes these difficulties in part to the fact that she and her husband have worked full time until the accident and the need to adjust to parenting roles caring for the children. She also reports that her husband has a problem with alcohol abuse, which she feels is related to his need to do extensive socialization and entertainment as part of his job. Finally, she reports their older son's cardiac disability has added stress on their marriage."

Q. Okay.

A. That's very different than what you just said.

Q. Well, it may be different from what I said, but go back to Page 1 of your report. Could you do that, please, Page 1. In the "Medical documents reviewed," they include records from Dr. Sontz, who's a psychologist, and those records were from February 16, 2012, to September 11, 2012, right?

A. That's correct.

Q. Have you reviewed those records in preparation for today's testimony?

A. Yes, I have.

Q. And you would agree with me that Dr. Sontz in February and

then all the way through to September basically recorded what Mrs. Irwin told her, correct?
A. That's correct.
Q. Okay. And Mrs. Irwin told Dr. Sontz that she was in a horrible marriage, her husband was terrible, he was an alcoholic, and he was verbally abusive, correct?
A. In essence, yes.
Q. Okay. And she also told Dr. Sontz that she wanted to get herself and her family away from that because it was an awful relationship, right?
A. That's correct.
Q. Okay. And in those reports, you would agree that Dr. Sontz also stated, as a result of interviewing Mrs. Irwin, that Mrs. Irwin was overwhelmed, overloaded, fatigued, and had great anxiety and depression, right?
A. Uhm, I don't agree with all of that.
Q. Okay. Well, we'll come back. That's okay. Fair enough.
MR. LAWLER: If you could put on the screen, I think it's 41, 41-A. Could you go to the last page of that. I think it's four of four.
Q. Do you see on the screen, Dr. Hibbard? Actually, just so it's fair, I'd like you to go back to the first page, please. Okay, Dr. Hibbard, I'm showing you 41-A, which is a report from Dr. Sontz. And I take it you've seen that several times before, right?

(Witness examining document.)

A. I'm not sure if I recognize this one as -- I've seen reports of hers. I'm not sure I have this report.

MR. LAWLER: Can I approach, your Honor, to see if the screen is the same?

THE COURT: Yes.

MR. LAWLER: I think it is, but --

Q. It is. Well, Doctor, look at your report, the first page of your report.

A. Yes.

Q. Just so we can marry it all up, do you see Dr. Sontz?

A. Yeah, I've seen it here because I realize down the bottom it's familiar.

Q. I'm sorry?

A. As I see it, down the bottom here, I remember reading this part of it. I didn't remember the top part of what it looked like.

Q. Okay. And why don't we go, just so your memory is properly refreshed that this is the right document, if you could the last, like, quarter of that page, just highlight it, that's fine. And see where it says, "Patient reports that her husband and his family are alcoholic. Patient is realizing that her husband is a terrible husband. She believes he is emotionally abusive and that he has been disrespectful to her (cheated with coworker and nanny). Patient has been married

for seven years and they were both drinking a lot then." Do you see that?

A. I do.

Q. Okay, so we're on the right document, correct?

A. Correct, yes.

Q. All right, if you could go now to Page 4. There's two other pages in between. If you want to see those, Doctor, I'll certainly show them to you, but are you fine going to this page?

A. Yes, uh-huh.

Q. Okay. Now, there's a diagnosis that Dr. Sontz provides in that February 16, 2012 interview and examination, correct?

A. That's correct.

Q. Okay. And I have in my hand here -- I'm just going to show the jury as well so this is --

MR. LAWLER: May I walk and show the jury?

THE COURT: Yes.

MR. LAWLER: Thank you, your Honor.

Q. This is DSM-V. You're familiar with this, right?

A. Yes, I am.

Q. Okay, this is the Diagnostic and Statistical Manual of Mental Disorders, right?

A. That's correct.

Q. And essentially it's the bible of psychologists, right?

A. That's correct.

Q. And you use it frequently, correct?
A. Correct.
Q. I know there were previous copies. There was DSM-IV and then DSM-IV-R, and now there's DSM-V, right?
A. That's right.
Q. So Dr. Sontz, she gave this diagnosis, correct?
A. That's correct.
Q. And this is 309.28, right?
A. That's correct.
Q. And 309.28, that's basically a -- excuse me. One moment. I'm going to get the actual page.
THE COURT: Mr. Lawler, when you get through these documents, we'll switch witnesses.
MR. LAWLER: Okay, I should be done with this point. I'll pick it up next time.
Q. Now, I'm on Page 287, and that 309.28, when expressed in the full language of DSM-V, says that Dr. Sontz diagnosed Mrs. Irwin as having an adjustment disorder with mixed anxiety and depressed mood. Would you agree with that?
A. I would agree with that.
Q. And would you agree with me that that diagnosis essentially says that a combination of depression and anxiety is predominant, right?
A. That's correct.
Q. Okay. So it's safe to say that Dr. Sontz was treating

Mrs. Irwin for symptoms of depression and anxiety, correct?
A. That's correct.
Q. Now, if you'd go back --
MR. LAWLER: A couple more questions, your Honor, and then we'll call it. If you'd go back to one page on that document, and if you could just highlight the top, that's right, the top, that would be great.
Q. Now, "Mental status exam," it basically states under "Mood" that she, she being Mrs. Irwin, is sad and angry, correct?
A. Correct.
Q. And when it says "Effect, congruent," what does that mean?
A. That means her emotional demeanor, does it match her mood, what she's talking about as sad and angry?
Q. Right, so when the word "congruent" is used, that basically means that the psychologist is evaluating the demeanor of Mrs. Irwin, and she's determining that her demeanor is both sad and also angry, correct?
A. That's correct.
Q. And I will continue whenever, I guess tomorrow. Thank you very much.
THE COURT: All right, jurors, we're going to give you a quick recess upstairs while we swap out the witnesses. See you tomorrow.
THE CLERK: All rise for the jury.

(Jury excused.)

MR. LAWLER: Just five minutes, ten minutes?

THE COURT: I think he's got a laptop to get hooked up.

(A recess was taken, 2:11 p.m.).

(Resumed, 2:18 p.m.)

THE CLERK: All rise for the jury.

(Jury enters the courtroom.)

THE CLERK: Court is back in session. Please be seated.

THE COURT: Call your witness, Mr. Charnas.

MR. CHARNAS: Dr. Brian Greenwald.

BRIAN GREENWALD, M.D.

having been first duly sworn, was examined and testified as follows:

THE CLERK: Could you please state your name and spell your last name for the record.

THE WITNESS: Dr. Brian Greenwald, and my last name is G-r-e-e-n-w-a-l-d.

DIRECT EXAMINATION BY MR. CHARNAS:

Q. Good afternoon, Dr. Greenwald. You're a medical doctor, correct?

A. That is correct.

Q. What is your specialty within medicine?

A. My specialty, I'm actually dual board-certified. I'm

specialized in both physical medicine and rehabilitation and also in brain injury medicine.

Q. What is brain injury medicine?

A. Brain injury medicine is a subspecialty which could be pursued by a physiatrist like myself, neurologists or psychiatrists. It's an area of specialization in the care of people with traumatic brain injury.

Q. And what is a physiatrist?

A. A physiatrist, which is my primary specialty, or physical rehabilitation or rehabilitation doctor, is caring for people with a variety of disabilities. Probably many of the people in the field deal with musculoskeletal disabilities, but myself, my area of subspecialty is dealing with people with disabilities from traumatic brain injury.

Q. Where do you work, Doctor?

A. I'm employed by JFK Johnson Rehabilitation Institute in Edison, New Jersey.

Q. And do you live in New Jersey?

A. I do.

Q. And what is JFK?

A. JFK is both a hospital and a rehabilitation institute. They are very well known for many years for the care of people with traumatic brain injury, of both more severe injury and milder injury.

Q. And tell us, what do you do there at JFK?

A. Well, I have a number of titles, but beyond my titles, more than half of my work is in patient care. I'm also involved with the administration there. I'm also the fellowship director there. I have a number of teaching roles there, but the majority of my work is just patient care of people with traumatic brain injury.

Q. How many patients do you see in a given week with traumatic brain injury?

A. I see about twenty -- I see twenty outpatients all together per week, which the majority of those people have traumatic brain injury, and my service is generally about ten inpatients on a given week.

Q. Could you tell us a little bit more about your clinical program at JFK.

A. Sure. It's both an inpatient practice and an outpatient practice. The inpatient practice is people who have injuries severe enough that they need to be hospitalized after their traumatic brain injury; and the outpatients is a mix of patients who were initially my inpatients and then became my outpatients, or people referred to me, many of whom have had mild brain injuries or concussions.

Q. Do you have any positions outside JFK?

A. I'm also, my academic position is, I'm an associate professor at Rutgers Robert Wood Johnson Medical School, is my primary academic position.

Q. Could you please summarize for us your education, training, and experience in the field of medicine.

A. Sure. I was an undergraduate at the State University of New York at Stony Brook, and then I completed my education there and stayed on there for medical school. After finishing my medical school training at the State University of New York at Stony Brook, I did an internship at the University of California San Francisco; and, as I promised my parents, I returned to the Northeast and did any residency training for three years in physical medicine and rehabilitation. After finishing my residency training, I did a fellowship training in brain injury medicine at Virginia Commonwealth University.

Q. Do you teach in the field of medicine?

A. I do. I'm actually the fellowship director for brain injury medicine, and I have residents, and I have a lot of teaching responsibilities through the medical school.

Q. And are you affiliated with any hospitals?

A. JFK Johnson Rehabilitation Institute, which is part of JFK Medical Center, and also Robert Wood Johnson University Hospital.

Q. At some point did you practice medicine in New York?

A. I did.

Q. Where?

A. For about ten years, I was over at Mount Sinai Medical Center in New York City.

Q. Did you know Dr. Hibbard at Mount Sinai?
A. I did.
Q. And what was your relationship with Dr. Hibbard?
A. Well, we worked in the same department and treated many of the same patients during that time. I think we overlapped for about five years in our time there.
Q. I think you may have answered this before, but are you board-certified?
A. I am. I'm board-certified both in physical medicine rehabilitation and in brain injury medicine.
Q. And you're licensed to practice medicine?
A. I am. I'm licensed to practice medicine where I see my patients in New Jersey.
Q. Have you ever won any awards in the field of medicine?
A. I've been lucky enough to receive a lot of awards, but some of the awards that I received, the Arnold P. Gold Foundation Award, which is for humanism in medicine, based on my caring and compassion for people with brain injury. That's a direct quote off the award. I was also the Physician of the Year at Mount Sinai. There's about two thousand physicians at Mount Sinai. I was elected by the nursing staff at Mount Sinai to be the Physician of the Year. I've won a number of other awards since, but most recently I was given the Angel Award. That was for clinical care and research for patients with traumatic brain injury.

Q. Do you have any leadership positions in any brain injury organizations?
A. I probably have two or three pages' worth of leadership positions, but probably some of the ones I'm most active in is with the American Congress of Rehabilitation Medicine. I'm pretty involved with their Disorders of Consciousness Committee, and on the flip side, also on their Mild Brain Injury Committee, the American Academy of Physical Medicine and Rehabilitation. I am the Vice Chair of Education for the Central Nervous System Council. For the Brain Injury Alliance of New Jersey, I've been on their Board of Trustees for about twelve years; and for the North American Brain Injury Society, I've also been on their Board of Trustees for, I guess it must be four or five years now.
Q. Have you ever gotten any grants from the government to do research in the field of brain injury?
A. I've had a number of grants, but I think the most significant ones were the Model Systems Grants. The Model Systems Grants is, every five years people compete for these grants. They're looking at -- it's a prospective grant looking at outcomes of people who have had severe brain injuries over the last 25 years.
Q. Doctor, what does it mean when a publication is peer reviewed?
A. So there are certain journals that are considered

peer-review journals, meaning that people, to be published in those journals, they need to send in their article. It's then reviewed by people who are considered experts in the area to see both if it's good science and if it's worthwhile to be published; and then if it is amongst three or four experts, it's then given the right to be published.

Q. Do you have any peer-reviewed publications?

A. About 30 peer-reviewed publications.

Q. Are they generally on the subject of traumatic brain injury?

A. Almost uniformly on that subject.

Q. Have you lectured in the field of brain injury?

A. I've given about a hundred lectures around the world, primarily in the field of brain injury rehabilitation.

Q. Do you happen to be attending a conference here in Boston right now?

A. I am. I'm stealing away from some leadership work that I'm doing for the American Academy of Physical Medicine and Rehabilitation.

Q. Have you ever been involved in creating any videos to help people with brain injury?

A. You know, obviously it's a great opportunity to be able to mass produce things to help people. I have created -- actually, Dr. Hibbard and I created a video that was useful. I think it was "The Many Faces of Traumatic Brain Injury." But

I've also done, through some of my charitable work, I've done a number of other videos to help people understand some of the challenges that they face after traumatic brain injury.

Q. Doctor, at some point did I ask you to consult in regard to this case?

A. Yes, you did.

Q. Have you and I ever worked before together?

A. No.

Q. What were you asked to do?

A. I was asked to evaluate Ms. Irwin, to review a set of records, and then to come together with an impression and a plan which she would need for her future as a result of the injuries that she sustained on 8/5/2012.

Q. Would you tell us everything you did to come up with that impression.

A. Sure. The first thing I do is, in a case like this, is to review as many of the records that I am provided, and I have a list here of the records that I was provided prior to seeing Ms. Irwin. Then I actually evaluated Ms. Irwin on March 10, 2014. Some additional records beyond that were sent to me. I reviewed those also. Those are all contained here in this report I received. So when I interviewed her, I also examined her, and then with all that information put together, I put together my impressions and her prognosis.

Q. When you examined her, what type of examination did you

conduct?
A. A basic head-to-toe examination, including a neurologic examination.
Q. I neglected to ask you, what does the term "impression" mean?
A. Based on all the information that I gained, both from the records that I reviewed and my interview and examination, what were my conclusions about her, what were the conclusions of the injury that she sustained, the impairments, problems, symptoms that she still has.
Q. And did you arrive at a medical impression in regard to Mrs. Irwin?
A. Yes, I did.
Q. And do you hold that impression to a reasonable degree of medical certainty?
A. Yes, I do.
Q. Tell us, what are your impressions?
A. My impression was that Ms. Irwin had sustained an injury to her head when she was hit by a wooden pole of a table umbrella on 8/5/2012. She had a brief loss of consciousness, or at least a period of post-traumatic amnesia, and was also confused after the injury, which had been documented. This meets the ACRM criteria for mild traumatic brain injury. She was then diagnosed by her treating clinicians both with a concussion and postconcussion syndrome. And then, as a result

of the mild traumatic brain injury, she has chronic headaches, dizziness, irritability, fatigue; impaired cognition, specifically looking at memory, organization, and concentration; anxiety, phonophobia, and photophobia.

Q. Now, you mentioned the ACRM and their criteria. Tell us about that.

A. The ACRM is the American Congress of Rehabilitation Medicine, and in 1993 they published a peer-reviewed paper looking at what are the clinical criteria to diagnose someone with traumatic brain injury. The criteria that they looked at is, one, is an injury to the head, but, two, is to have one of the -- only one of the four things. One was a loss of consciousness; two was that the person was dazed or confused afterwards; three, that they have a period of post-traumatic amnesia, either an inability to remember what happened right before the accident or right after the accident; or, four, that they have a focal neurologic sign, something like a seizure or partial visual loss, and, again, this is immediately after the accident. You only need one of those four criteria to meet the ACRM criteria for mild brain injury. And that was back in 1993. Since then, there's been a number of organizations that have looked at these criteria to see if they are really the right criteria, and that includes the World Health Organization and the American Academy of Neurology, and most recently the military; and all three have written papers about these

specific criteria but have really maintained basically those criteria that I just outlined to make the diagnosis, the clinical diagnosis of mild traumatic brain injury.

Q. What's the basis of your belief that -- well, which of the criteria did she meet?

A. Well, specifically, we talked about the confusion that was well documented, but also by history, having a period of either a brief loss of consciousness or post-traumatic amnesia. The hard part, of course, is if someone has a period of post-traumatic amnesia, meaning something that they don't recall immediately afterwards, they may not know if there was a loss of consciousness or not.

Q. Why do you believe that she had a period of post-traumatic amnesia? Based on what?

A. Based on her history that I obtained, but also the information that I had was also supplemented by the people who saw her afterwards; specifically, the statements from Katie Hildreth and Meghan O'Neil.

Q. When you say she had confusion, what are you basing that on, Doctor?

A. In the ambulance ride on the way home, part of the reason that they were so concerned for her is the confusion that they noted, which is why they then said that she had a Glascow Coma Scale score of 14, and began treating not only her son but her too.

Q. And what's the Glascow Coma Scale?
A. So the Glascow Coma Scale, also called the GCS, is a measure of consciousness or unconsciousness, is primarily what it's meant to look at. It looks at eye movement, verbal abilities and motor abilities. It starts at 3 is the lowest that you can get, meaning the person is deeply unconscious, through 15, meaning that the person is alert and oriented, able to move their arms and legs. With the confusion that she was having, they scored her verbal score as one point lower and gave her a totally Glascow Coma Scale score of 14.
Q. And why is that significant?
A. Again, it speaks to the confusion that she was having. Patients who have had mild brain injuries or mild-severity brain injuries usually have a Glascow Coma Scale score of 13 to 15.
Q. Just so it's clear, what's the period of post-traumatic amnesia that you're talking about?
A. Just not being able to recall what happened immediately before or after the accident.
Q. But in her case specifically?
A. Let me look specifically at what she told me.
(Witness examining document.)
A. So she recalls that she was hit in the face, and then the next thing she recalls is that her mother was putting ice on her face, but has no recollection of what happened between the

umbrella heading towards her face and then her mother putting ice on her face. So with that situation, it would be hard to say if someone had a loss of consciousness versus a period of post-traumatic amnesia. Either way, she has clearly a period of well-documented confusion, so she would meet the criteria even if we are just talking about the confusion period.

Q. You used the term "mild traumatic brain injury" several times. What do you mean by that?

A. So the severity of traumatic brain injury is often broken up or talked about as mild, moderate, or severe. So it doesn't actually relate to what your symptoms and your disability is later on. It's really just based on what you look like initially. If initially when you show up to the emergency room after they resuscitate you you're awake, you're deeply comatose, your DCS, you're going to be a severe brain injury no matter how good of an outcome that you have, if you show up to the emergency room and you're only dazed and confused, you'll be considered to have a mild brain injury, no matter how many impairments that you continue to have.

Q. Now, is there a difference between the terms "impression" and "diagnosis"?

A. The diagnoses are more specific. So in her case, let's say that the traumatic brain injury is the diagnosis, but my impression -- and my impression goes on for a number of pages -- it gives sort of my overall thoughts and also gives

the specifics of why I think that.

Q. Go ahead.

A. Well, we talked a little bit about that she was confused on the way to the ambulance and was taken to South Shore Hospital, and that the following day she had headaches and nausea and photophobia and phonophobia and blurred vision. These are really the most common symptoms that we see in persons who have had a concussion, these specific set of symptoms, sometimes called "postconcussion syndrome" because they're such a common set of symptoms that go together. We talked a little bit about then that she had been pending a breast mass removal; and because she was still symptomatic from the concussion, her neurologist had recommended that she hold off in having that done, and she waited secondarily on having that excised for about a month. Then Dr. Lash, her primary care doctor, seeing that she was still symptomatic, referred her to Dr. Sun, who ordered an MRI and EEG, and she was then treated by Dr. Sun for about a year. Dr. Sun then referred her for cognitive therapies at the Center for Cognition and Communication. She actually tried to get back to work, but some of the computer -- the computer work that she had done at the Center for Cognition and Communication actually worsened her headaches, which is why she didn't continue to treat there.

It's noted in the record that her primary symptoms were fatigue and headaches and irritability and sensitivity to

noise, as well as sensitivity to light, fogginess, dizziness, and misspeaking. Symptoms were all worse when she was fatigued.

Q. Why are all these symptoms significant to you?

A. These are -- when you look at what are the core symptoms that we see in persons who have had traumatic brain injury, actually even more commonly in people that have had mild traumatic brain injury, these are the symptoms. The CBC has a nice brochure that they have on the most common symptoms that we see after traumatic brain injury, the 20 most common symptoms. These would all be the exact symptoms that are on there for mild traumatic brain injury.

Q. I interrupted you. Please finish with those symptoms, if you would.

A. And then she talked about how when she tried to return to work, that she couldn't follow the conversations, she mispronounced the names, and all the challenges that she had when she did try to return to work for the time that she was trying to return to work.

I then talked about how that although she does have life stressors, including stressors with her child and with her husband, these had been prior to 8/5/2012, and it never stopped her from her profession or success. She had been the sales representative of the quarter from Shire Pharmacy in the months prior to her injury. I think that really speaks about what she

was like prior to her injury, which is certainly an important consideration in my evaluation of her.

I then talked about how CT scan and standard MRIs wouldn't have the resolution needed to see the external damage that I would expect from the injury that Ms. Irwin --

Q. Could you slow down a little bit because you're reading, and I know that you're going fast.

A. Sure. I noted then that CT scan and MRI wouldn't have the resolution, the standard MRI, at least, wouldn't have the resolution to look for the white matter damage that I would expect from such an injury that she sustained on 8/5/2012; and I talked a little bit about then that it's the white matter damage that we see on the MRI --

MR. LAWLER: Objection. Your Honor, request a sidebar.

SIDEBAR CONFERENCE:

MR. CHARNAS: I'll try to refocus him. I get it.

MR. LAWLER: No, no, no, that's not it.

MR. CHARNAS: Oh.

MR. LAWLER: Well, that's part of it. The other part is, though, he's about to testify about these DTIs, these advanced MRIs. He has no real expertise in this particular field. Dr. Benson is coming in tomorrow to talk about this. I can show you the pages in the deposition where when I'm questioning Dr. Greenwald and I'm getting into the specifics

about FA and the way they do these particular DTIs and all that, that he basically says --

MR. CHARNAS: Here's what's going to be the evidence, Judge: In his clinical practice, he relies regularly on DTIs; that he doesn't understand the FAs and the things that Dr. Benson does, just like I don't understand how an X ray works. But he uses it every day in his clinical practice, and he's going to testify that after he came to a diagnosis, he looked at the DTIs scans and they confirmed his diagnosis. If he uses it in his clinical practice every day, how can you say he can't use it in the courtroom?

MR. LAWLER: When I questioned him at his deposition, and I can cite it, I started asking him questions about the whole procedures and all that, and he said, "Mr. Lawler, ask Dr. Benson. You're going to depose him. I don't know what you're talking about," basically.

Now, in addition to that, he basically says that he cannot tie in the DTIs -- the DTIs are these advanced MRIs -- we know about that -- he cannot tie that into the August 5, 2012 incident. He cannot. He cannot do it. He said that.

MR. CHARNAS: Judge, we're revisiting the same argument about keeping Dr. Benson off. The Court has already ruled.

THE COURT: I will allow him to testify to the fact that he made a diagnosis, and it was corroborated by what he

understood the results of the DTIs were.

MR. CHARNAS: That's all he's going to do.

MR. LAWLER: But, no, and I want this on the record, please. In addition to that, Dr. Greenwald in his deposition says that he cannot tie in -- as we know, there's been several other concussions -- so he cannot tie the readings of the DTIs that were done by Dr. Benson into the August 5, 2012 incident. Then, therefore, therefore, the probativeness of that particular testimony is minimal, and the prejudicial value is extreme because you're basically not able to have the jury hear that she has all these white matters, and they have no information to go on --

THE COURT: They are going to hear about the white matters tomorrow.

MR. LAWLER: I know, but that's one thing.

MR. CHARNAS: This is the same argument that was made to keep Dr. Benson's testimony out. The Court has already ruled on that. I'm only going to ask him if just as the chart says --

THE COURT: And then you can cross-examine him.

MR. LAWLER: Oh, I plan to, but what he's doing is, basically he's just regurgitating what Dr. Benson says, so it's cumulative.

THE COURT: He can't do that. What he can say is that he looked at it, he made his diagnosis, and then he had

Dr. Benson's results, and based on his experience, that corroborates, but that's it.

MR. CHARNAS: That's it. That's all I'm doing.

MR. LAWLER: That's fine. Thank you.

(End of sidebar conference.)

BY MR. LAWLER:

Q. Doctor, let's get back to the symptoms of mild traumatic brain injury that you saw in Mrs. Irwin. Please continue.

A. Okay, I'm saying that the impairments and symptoms that she has, including the cognitive impairment, the mood impairment, fatigue, the headaches, the sensitivity to light and noise, and the dizziness, were secondary to the white matter damage that she had from 8/5/2012. There was no evidence from her prior concussions that she had any sequelae or any problems from them. She was functioning well as the mother of three children and a successful salesperson prior to her injury. And then I discussed that given her complex impairments that she had, I do not believe she would be able to return to a competitive sales position; that if she were able to return to work, that she would need a structured, slow-paced position that would secondarily be less financially rewarding.

I then went over the future medical needs that I believe that she has as a result of the injuries that she sustained on 8/5/2012.

Q. Well, we'll get to that in a second. By the way, I

neglected to ask you, your diagnosis of mild traumatic brain injury, do you hold that to a reasonable degree of medical certainty?
A. Yes, I do.
Q. Now, the symptoms that you've gone over for us, do you have an opinion as to whether those symptoms are consistent with mild traumatic brain injury?
A. They are consistent with mild traumatic brain injury.
Q. And the basis of that again is what?
A. These are the core symptoms that we see. A, she was diagnosed with mild traumatic brain injury based on the clinical criteria that I discussed earlier. B, she's had a consistent set of both impairments and symptoms that have been noted by her clinicians that have treated her, but, C, then the findings on my own examination.
Q. Doctor, what does the term "objective evidence" mean?
A. It's something that if two people looked at the same thing, they should be able to come to the same conclusion.
Q. Is it something that can't be faked?
A. That is, correct.
Q. So, Doctor, did you determine whether there was any objective evidence of mild traumatic brain injury?
A. When you say of mild traumatic brain injury, do you mean the sequelae or that actually --
Q. Either one.

A. Objective evidence, well, one, radiology is obviously objective evidence. I know Dr. Benson is going to be testifying on that. I'm okay not to go into detail with that if you'd prefer.
Q. Well, we'll talk about the DTI in a moment, but other than that.
A. I'll leave that to the side for the moment. Certainly on examination, there is clear evidence that when you speak with her about her inability to maintain a topic, her slow in processing and asking questions of her, on her physical examination, particularly looking at her extraocular movements, which are so commonly impaired in people with vestibular impairment -- she nearly fell with just doing some extraocular muscle testing -- again, objective evidence on examination of the impairments that she has, and very consistent also with the complaints that she has or the symptoms that she has.
Q. There's a reference in Dr. Collins' record to saccades, if I'm pronouncing that right. What are saccades?
A. Saccades is really the eye movement from left to right, which is generally smooth as you're looking across the room. It's not like your eyes are jumping that way. They're actually smoothly going from left to right, although you may vary how quickly you do that, where in her case, you can see on examination that her saccaads (Phon) --
Q. Sorry.

A. -- are abnormal, and is part of the reason that she, when I was doing her extraocular muscular testing, she nearly fell.
Q. Now, Doctor, once you confirmed the diagnosis of mild traumatic brain injury, did you do anything to corroborate that diagnosis?
A. That's the comprehensive record review that we did, the evaluation from the neuropsychological testing, but really the diagnosis is made on those clinical criteria.
Q. Once you made that diagnosis, did you see a diffuse tensor imaging scan or scans?
A. I did.
Q. Okay, now, I know you're not the expert in diffuse tensor imaging, also called DTI, but do you use DTI in your clinical practice?
A. In my clinical practice, I commonly will order an MRI with diffusion tensor imaging.
Q. Can you give the jury just a general understanding of what DTI is.
A. Sure.
MR. LAWLER: Objection.
THE COURT: Sustained. Ask him why he orders it.
Q. Why do you order it?
A. Well, it goes back to why a standard CT scan and a standard MRI are not useful is why I order that specifically. So standard CT scan really does a good job at looking at bone,

it looks at large hemorrhages, but is not very good at looking at the brain tissue. In our little heads, there's about a hundred billion axons. Axons are the telephone wires that bring information around the brain. So you can imagine, if there's a hundred billion in our heads, that they're microscopic in width.

Secondarily, when we do a standard MRI of someone's head where we're just looking grossly at their brain tissue, it gives us no information about, one, about the structure of the axons, these microscopic tubes, but, two, it tells us nothing about their function at all. An MRI with diffusion tensor imaging is a technique that allows us to look for white matter damage which wouldn't be evaluated on standard scans, so it gives us an advantage that way.

Q. Doctor, you mentioned diffuse axonal injury. I think you had chart that might be useful for the jury, if we could have that on the screen.

MR. LAWLER: Objection, your Honor.

THE COURT: What's the basis?

MR. LAWLER: What we talked about at sidebar and what the instructions were to the witness.

THE COURT: All right, let's talk over here.

SIDEBAR CONFERENCE:

MR. CHARNAS: First of all, I've shown this to the opposing party. He said it was okay. That's the first thing.

The second thing, it shows diffuse axonal injury. It's got nothing to do with DTI.

MR. LAWLER: Well, I think it does completely have to do with DTI because that's what DTI shows. It was my understanding when we were here five minutes ago that you instructed him to say basically that he sent this information to Dr. Benson so he could corroborate it, and that's it. And so now we're getting into all this explanation --

THE COURT: Does this have anything to do with DTI?

MR. LAWLER: Well, that was my understanding. If I'm mistaken, then I'm mistaken.

MR. CHARNAS: It shows axonal injury and shearing injury.

MR. LAWLER: But that's what DTI shows.

MR. CHARNAS: -- we can talk about the brain because the DTI shows it.

THE COURT: He's not talking about DTI. He's talking about -- he shouldn't talk about DTI, but he can talk about the brain.

MR. CHARNAS: He's talking about what happens when you have brain injuries, you have diffuse axonal injury. He's going to talk about that. Now, DTI shows the diffuse axonal injury, but that doesn't mean he can't talk about it.

THE COURT: Okay, well, then go into it.

(End of sidebar conference.)

BY MR. CHARNAS:

Q. Can you see that, Doctor?

A. I can.

Q. What are we looking at here?

A. This is an educational model that I've used in trying to explain what diffuse axonal injury is. It gives you an idea of the brain there, you can see on the left. If I draw on this, will it come up?

Q. Yes.

A. Okay. Here's this crazy-looking structure that is our brain that controls everything we are, all our memories, all our mood, our vision, our hearing. Everything ours is in this crazy-looking structure here, the brain.

With that said, as I was mentioning, in that brain is about 100 billion axons. Axons are the telephone wires that bring information around the brain. That's sometimes called the white matter. The gray matter sits on the outside of our brain. The gray matter is all the little computer cells that allow me to speak and allow you to understand the information. Here on the right side -- you can appreciate this -- is an enlarged version of what axons would look like if they were in a bundle. Again you can see here sort of at the edge this purple area here is the gray matter, the little cell bodies; and the axons, also called the white matter, are coming off of them, again, taking information to different parts of the

brain.

Now, remember that the skull itself is very hard, or at least mine is, but inside the brain is soft. It's like formed Jell-O. So when enough pressure, enough force is applied to the skull, it's not hard to injure the brain underneath.

Primarily the injury in a mild brain injury or in a concussive injury like this is to the white matter, is both shearing, meaning a mechanical force to the white matter, a stretching of the white matter, but then also goes on to be what's called a neurometabolic injury, meaning an injury, an inability then of those axons, those telephone wires, to bring information down those axons. When that occurs, that brings on the symptoms and the impairments that would commonly occur. This has been understood for some time but is really understood much better over this last ten years as we've done so much more research on our injured veterans and our injured athletes.

Q. When someone sustains mild traumatic brain injury, is it just the immediate structural damage to the brain that creates symptoms for the person who has that injury?

A. The structure is actually the first part of it, and it's that stretching of those axons as the forces goes from the skull and into the soft tissue of the brain. Really, that starts off a neurometabolic cascade, which injures both the cytoskeleton, the skeleton of the axons, the skeleton of that

telephone wire, but also what's called the myelin sheath, which is the insulation around that axon; and sort of like a telephone wire or an electrical wire, if the sheath, the insulation around it is injured, it's certainly not going to be able to conduct that information or that electricity well. No different of what we see in mild brain injury when the axons are injured and the insulation of that axon is injured due to the forces that we were talking about, the information is not able to be sent back and forth down those axons. So the axons are still sitting here. It's not like we're saying that they've died off. They're just not able to move the information around the brain.

Q. You mentioned the term "neurometabolic cascade." What did you mean by that?

A. So what's happening, it's not such a simple process as when electricity is going down a copper wire and the electrons are just moved down the wire. It's a very complex process that's going on as information is brought down the axon, and that involves a number of different microscopic parts inside that axon. That shearing injury to the axon, that pressure on the axon, causes injury for the ability to move that information down the axon, sometimes causing abnormality of the neurometabolic cascade.

Q. Thank you. Dr. Greenwald, so in your practice, you sometimes ask for DTI to be done; is that correct?

A. Yes. I'll sometimes send people for not just the standard MRI but MRI with diffusion tensor imaging to allow me to look at damage in the white matter.

Q. And how long have you been doing that?

A. I'd say it's been at least ten years.

Q. And did you look at DTI in regard to Megan Irwin?

A. I did.

Q. And who did the DTI analysis?

A. That was Dr. Randall Benson.

Q. And did that DTI confirm your diagnosis of mild traumatic brain injury?

A. It was consistent with my diagnosis.

Q. And tell us the basis of your answer.

A. Again, in someone with a mild brain injury, the injury is generally to the white matter. So if I had not seen any white matter damage, it would have made me think that there is some sort of other psychological component or some other reason that she'd come up with such a set of symptoms. Knowing both that she was functioning well prior to her injury, clearly had an injury that would cause such white matter damage, had symptoms immediately afterwards, has sustained symptoms since, it further corroborated my diagnosis of mild traumatic brain injury.

Q. Now, like an X ray, if you look at the DTI scan, can you tell when the brain damage occurred?

A. You could not tell. It does not give you a time to it. It's not time stamped.
Q. So how did you come to the conclusion that that brain damage that showed up in a DTI was caused by this incident?
MR. LAWLER: Objection.
MR. CHARNAS: Let me withdraw that.
Q. Do you have an opinion as to whether the traumatic brain injury suffered by Megan Irwin is causally related to the incident of August 5, 2012?
A. I do.
Q. And do you hold that opinion to a reasonable degree of medical certainty?
A. Yes, I do.
Q. And what is that opinion?
A. That Megan Irwin had no evidence that she had any impairments or any of the large set of symptoms --
Q. Well, before you tell us the basis, what's your opinion?
A. My opinion is that Ms. Irwin sustained a traumatic brain injury on 8/5/2012 and has substantial impairment as a result.
Q. And what's the basis of your opinion?
A. Is my record review, including the MRI with diffusion tensor imaging, my interview and examination.
Q. Now, Doctor, are you aware that she had prior concussions before August 5, 2012?
A. I am.

Q. And how do you know that these prior concussions aren't what's causing her symptoms?
A. Well, there's no evidence that she had any of these symptoms. There's certainly no evidence that she had any of these impairments despite the previous concussions and stressors in her life. There's no evidence that anything minus this injury itself was the cause of these impairments.
Q. Well, are you aware that she had prior instances of anxiety, at least one prior instance of fatigue? Are you aware of these things?
A. I am.
Q. And that she had prior headaches from time to time, are you aware of that?
A. I did note that.
Q. So does that affect your opinion?
A. It does not.
Q. Why?
A. I know that there's individual instances of mention of her feeling fatigue in her records, and I reviewed extensive records over time. I know that there's individual instances of noting headaches, but there's no, A, there's no diagnosis; there's no chronicity to those symptoms. Unlike what we've seen since 8/5/2012 where she's consistently been noted to have these impairments and symptoms, that wasn't true of any of the records prior to 8/5/2012.

Q. Doctor, do prior concussions make one more susceptible to more severe and/or longer-lasting symptoms in the event of a subsequent concussion?

A. There's good evidence for that, that having had one concussion, and each successive concussion puts you at higher risk of symptoms for that. There's very good data, especially from our athletes, showing that there is cumulative effects of concussion, and that there may be even a threshold above and beyond that it may not be worth it to participate in athletics, and therefore that it would increase your risk of permanency to the symptoms.

Q. Doctor, in the course of your evaluation of Megan Irwin and writing a report in this case, did you make any recommendations for future treatment?

A. I did.

Q. And tell us, what recommendations did you make? And this is back in the spring of 2014, I believe, correct?

A. That is correct. I recommended that Ms. Irwin be treated by a specialist in the care of traumatic brain injury, someone like myself. I recommended that she have cognitive remediation by a neuropsychologist to maintain compensatory strategies for cognitive impairments. I recommended that she have family counseling with her husband to educate her husband and assist with the change of their relationship, given her functional limitations. I recommended that she have vestibular therapy.

I recommended pharmacologic treatment of her fatigue and cognitive impairment and mood impairment, and I gave specific recommendations for that.

I recommended that she have an evaluation by a neuro-optometrist for her traumatic brain injury and these visual impairments. I recommended that she have childcare to assist while she's engaged in therapies, and that she have vocational evaluation when her symptoms are better controlled and her impairments are lessened.

Q. Doctor, have you had an opportunity to review additional medical records on Mrs. Irwin since you saw her in the spring of 2014?

A. Yes, I have.

Q. And has she made any improvement?

A. The records that I saw discussed the ongoing impairments and symptoms that she had similar to when I had seen her in March of 2014.

Q. Doctor, do you know what a vocational counselor is?

A. Yes, I do.

Q. Are you a vocational counselor?

A. I am not.

Q. Do you have an opinion as to any type of labor that Mrs. Irwin would be suited for?

A. Given her current constellation of symptoms and impairments, I couldn't imagine a job that she would be able to

do.

MR. LAWLER: Objection. Sidebar, please.

THE COURT: If I sustain the objection, could we skip the sidebar?

MR. LAWLER: Could I have the answer stricken, please?

THE COURT: The objection is sustained, and the answer is stricken.

MR. LAWLER: Thank you.

Q. Doctor, generally speaking, what does the term "prognosis" mean?

A. The likelihood of something getting better or worse.

Q. And do you have a prognosis for Megan Irwin?

A. That Ms. Irwin's symptoms are permanent, that I wouldn't expect them to show any further improvement, and her impairments are permanent.

Q. What's the basis of your opinion that her impairments and her mild traumatic brain injury are permanent?

A. Well, it's generally considered in the medical field that after about a year of time, the brain will have fully recovered as much as it can. What we see in times of improvements beyond a year is generally more compensatory in nature, as in learning ways, work-arounds, more than actually the brain tissue itself improving. I would say that that said, now that it's been three years or more than three years since her injury, or even two years when I had seen her at that point, her brain injury

impairments would be considered permanent.

MR. CHARNAS: Thank you. That's all I have, Doctor.

MR. LAWLER: Thank you, your Honor. It's just going to take me a second to set up.

CROSS-EXAMINATION BY MR. LAWLER:

Q. Good afternoon, Doctor. John Lawler. We met about a year ago.

A. Good to see you again.

Q. How are you?

A. I'm doing okay.

Q. Doctor, when were you retained in this particular case?

A. It was in the months prior to March 10, 2014.

Q. And as part of your work in this particular case, you completed a report; is that correct?

A. That is correct.

Q. And that report is dated April 25, 2014, right?

A. That's correct.

Q. And, Doctor, do you have that in front of you?

A. I do.

Q. Now, this report basically articulates your opinions as of April 25, 2014, correct?

A. That's correct.

Q. And it also articulates what type of work you did on this particular file, right?

A. In this report?

Q. Yes. I mean, this -- well, first of all, do you do any other expert testifying in medical legal cases?
A. I do.
Q. And how long have you been doing that for?
A. Since about 2003 or 2004, so about ten years or so.
Q. Okay. And obviously, I mean, you were retained in this particular case by Attorney Charnas, correct?
A. That's correct.
Q. And you charge a fee for your hourly services, right?
A. That's correct.
Q. And your fee in reference to this particular case was $700 an hour; is that right?
A. Actually, it was $600 an hour for this work that I have done on this case.
Q. Okay. And then when I deposed you last year for approximately five to six hours, you charged me $6,000, correct?
A. No.
Q. How much did you charge?
A. Let me take a look, but it was $700 an hour. I believe it was around $3,500.
(Witness examining document.)
A. Let's see. I'm sorry, you're right. It was $4,900.
Q. Okay. I have in my hand a fee schedule for you, and you obviously created that, correct?

A. That's correct.
Q. And it's safe to say that for today, to testify in Boston in this particular case this afternoon, you charge $10,000; is that right?
A. That's correct.
Q. And in this particular case, you spent approximately eight hours of work on this particular case, is that right, up until the time you completed the report?
(Witness examining document.)
A. That's correct.
Q. And of that eight hours, you essentially reviewed records and completed your report, and that took about seven hours, and then for the eighth hour, you met with Mrs. Irwin, correct?
A. That sounds correct.
Q. So essentially what you did was, you reviewed reports and records, and then you completed your report, and you saw Mrs. Irwin, and you did that all in eight hours; is that right?
A. That sounds correct.
Q. Now, as I said before, you've been an expert witness on a regular basis since 2004; is that correct?
A. Approximately, yes.
Q. Okay. And you talked about different businesses that you were involved in early in the direct examination. You remember, right?
A. Yes.

Q. Remember that? Okay, you didn't mention that you have a separate corporation called -- what is it, Brian Greenwald, LLC, limited liability corporation?

A. That's the corporation that does these medical legal evaluations.

Q. Okay. And in your work, you primarily work for plaintiffs like Mrs. Irwin, correct?

A. That is correct.

Q. And in regard to your examination and work in regard Mrs. Irwin, it's safe to say that you never talked to any of her family members? You just spoke to Mrs. Irwin, right?

A. That's correct.

Q. Okay. How much time have you spent between the time you completed your report and excluding the time that you did the deposition, how much time have you spent on this particular case? Do you have a record of that?

A. So since I completed the report and excluding the deposition, is that correct?

Q. Right.

A. I reviewed -- yesterday I reviewed the new records and then looked over my report, so I spent about, in this last 24 hours, probably spent another two hours in looking over information.

Q. Okay, so just so I can, you know, clarify this for the ladies and gentlemen of the jury, you completed your report on

April 25, 2014, correct?
A. Correct.
Q. And by reviewing records, completing the report, and meeting with Mrs. Irwin, that totaled eight hours, right?
A. That's correct.
Q. And other than being deposed in the case, the next time you did any work on this particular case was yesterday; is that right?
A. Actually, there was an affidavit that was created in between.
Q. Okay. And when was that affidavit created?
A. Let's take a look.
(Witness examining document.)
A. It was in April of 2015.
Q. Okay.
A. That was one hour worth of work.
Q. So let's go back to the first page of your report. Except for the records that you reviewed yesterday, the report specifies the records that you received and reviewed up until yesterday, correct?
A. I had received the additional records prior to yesterday, but I reviewed them yesterday.
Q. Okay. So the first record was the Cohasset Fire Department Ambulance Report, right?
A. Correct.

Q. And then there was a report from the South Shore Hospital, and that was the one dealing with the treatment of Mrs. Irwin on August 5, 2012, right?
A. Correct.
Q. Then there's a report from Dr. Dexter Sun?
A. There's extensive records from him.
Q. Okay. Also some records from Dr. Jason Brown and Dr. Michael Collins. I think they were two individuals out of Pittsburgh. Is that right?
A. No. Dr. Brown is in New York, and Dr. Collins is in Pittsburgh.
Q. Okay. And then NYU Langone, right?
A. Correct.
Q. And then Dr. Laura -- and I'm not going to do very well with this name -- Noeleski?
A. Correct.
Q. And then Dr. Meredith Lash, right?
A. Right.
Q. And then Dr. Jennifer Sontz, correct?
A. Correct.
Q. And then Dr. Aaron Pearlman, right?
A. Right.
Q. And then Dr. Michael Stewart, right?
A. Correct.
Q. Okay, those were the only medical records that you

reviewed in regard to this particular case, right?
A. Actually, the records also of Dr. David Stone.
Q. Oh, I'm sorry. I'm sorry. Thank you. There's a bunch of different answers to interrogatories and statements, but the last one is records from David Stone, right?
A. That's correct, yes.
Q. So those were the records that you looked at and considered before you wrote this particular report, right?
A. That's correct.
Q. Now, in regard to your examination of Mrs. Irwin, what day did that take place on?
A. That was on March 10, 2014.
Q. And where was that evaluation held?
A. That was done at Rehabilitation Specialists in Fairlawn, New Jersey.
Q. Okay. And Mrs. Irwin came to that evaluation by herself; is that right?
A. That's correct. She was taken by taxi to that evaluation.
Q. Okay, but did she come by herself?
A. She came by herself, yes.
Q. And was there anybody else present during your evaluation, or is it just you and Mrs. Irwin?
A. Just me and Ms. Irwin.
Q. Now, in reference to your report, I want to draw your attention to Page 18. And, by the way, Doctor, how many pages

is your report?
A. My report is 30 pages.
Q. How long does it take you to create a report like this, three or four hours?
A. I think we discussed it already. It was a total of eight hours, minus the hour for evaluating her.
Q. Well, that includes the record review, right?
A. The way I do the record review is, I dictate it out into a Dictaphone. Then it goes off to be typed up.
Q. Okay. So on Page 18 and then Page 19, you list a number of current problems caused by injuries sustained on August 5, 2012, right?
A. That's correct.
Q. Okay. And then you list under that category essentially twelve symptoms or problems; is that right?
A. Impairments and symptoms, yes.
Q. Okay. So stay with me on this one. So you go down the list: "Headaches, dizziness, feeling of being foggy, irritability, fatigue, tiredness, difficulty with organization and planning, anxiety, easily overwhelmed, sensitivity to light and noise, frustration over not recovering it, difficulty with word finding," and then "deviated nasal septum and recurrent sinus infection." I read those, right?
A. You did well.
Q. Well, I didn't do a great job, okay. Good enough. So the

next sentence in your report states, "Prior to August 5, 2012, she was not having any symptoms as above," right?
A. Correct.
Q. Okay. And I assume when you use the word, the pronoun there "she," you mean Mrs. Irwin; is that correct?
A. Yes.
Q. And tell me, Doctor, when it basically says, "Prior to August 5, 2012, she was not having any symptoms as above," is that her telling you that, or is that your diagnosis or your opinion or your impression?
A. Well, that's not part of my impression. That was my asking her the problems that we were discussing, that we just discussed, the last twelve issues that we discussed, "Were you suffering from any of these prior to 8/5/2012, certainly on a regular basis?" and she said "No."
Q. Okay. So you go through all these twelve categories, and Mrs. Irwin basically says, "Doctor, I didn't have any of these before the August 5, 2012 incident," is that right?
A. No. Actually, I don't go through that much. This is an open-ended question: "Tell me the problems that you have been having since 8/5/2012." I don't actually say, "Do you have any irritability?" It's not like that.
Q. But would you agree with me that you say, after the listing of those twelve items, that it says, "Prior to August 5, 2012, she was not having any symptoms as above"?

A. That's correct, that's what it says.
Q. Okay. And so going back to the page in front of that, which is Page 18, the first item is "headache," okay? And you reviewed the records of Dr. Lash, correct?
A. Correct.
Q. And you remember, for instance, that there is talk in 2008 about Mrs. Irwin striking her head and then having basically a concussion, and, as a result of that, having headaches for a number of months, right?
A. I know it said that she had a headache immediately afterwards.
Q. Okay. You don't remember the record that indicates that she had the headaches for several months after that?
A. I saw that there are records that say that she did have headaches for a period of time afterwards, which had abated or stopped.
Q. Okay. Are you also aware that in December of 2011, that Dr. Lash also treated Mrs. Irwin for headaches at that particular time?
A. That she treated or as noted as one of her complaints?
Q. Well, it was noted as one of her complaints. Does that sound familiar to you?
A. I know that there are individual instances of that throughout the records, yes.
Q. Okay. And so the next item is dizziness. Can we put them

on the board just one after the other. So the first one was headaches. The second one is dizziness. Now, did you do any tests to determine dizziness?

A. I did.

Q. Okay, is there a test called the nystagmus?

A. It's not a test.

Q. Okay. What is nystagmus?

A. Nystagmus is looking at jerky eye movements as you're moving from one side of your eye field to the other.

Q. Okay. And does nystagmus deal with dizziness?

A. You can get dizziness from nystagmus.

Q. Okay, so explain to the jury how you do the test for nystagmus.

A. So you ask the person to look at your finger. You ask them to move to the left and move to the right, and you watch the eye movement as it goes through. That's what we were talking about earlier, that saccades versus saccaads (Phon), but, again, looking at sort of the smoothness of the pursuit, and I did that, and the abnormalities on her exam are noted in my record.

Q. Okay. But in regard to nystagmus, there was no nystagmus, right?

A. I did not see nystagmus.

Q. Okay. And nystagmus is an objective test; is that right?

A. It's an objective finding, but it's not a test.

Q. Okay, it's an objective finding?
A. Correct.
Q. Because you can see it or not see it, right? Basically is that it?
A. Correct.
Q. Okay. And Mrs. Irwin did not have nystagmus, correct?
A. Correct.
Q. Now, irritability, were you aware that Mrs. Irwin suffered from irritability and anger issues prior to August 5, 2012?
A. On a chronic basis, or did she feel that only when she didn't have coffee?
Q. I'm sorry, I didn't get that.
A. Did she feel chronically irritable on a chronic basis or only when she didn't have coffee?
Q. Okay, I mean on a chronic basis, not when you miss your coffee in the morning.
A. And I feel that way sometimes. I did not see throughout the records that she had chronic irritability.
MR. LAWLER: Could we pull up 41-A, please.
Q. Doctor, you had a chance to look at some of the records from a Dr. Sontz, correct?
A. Correct.
Q. And you would agree with me that Dr. Sontz is a psychologist who treated Mrs. Irwin starting on February 16, 2012, till September 11, 2012, right?

A. That's correct.
Q. Okay. And have you reviewed all of her records?
A. I reviewed, I believe, all of her records.
Q. Okay. Were you aware that Mrs. Irwin was diagnosed in February of 2012 by Dr. Sontz as suffering from an adjustment disorder with mood and anxiety issues?
A. I'm aware of what an adjustment disorder is. I don't know that ICD-9 code specifically.
Q. Okay, you're not aware of the 309.28?
A. My knowledge base is large, but I am not specifically aware of 309.28.
MR. LAWLER: May I approach, your Honor?
THE COURT: Yes.
Q. Do you work with DSM-V at all?
A. I'm familiar with DSM-V. I'm not a psychiatrist, but I'm familiar with it.
Q. Can I step up there.
A. Oh, please.
Q. Thank you. So I'm showing you right here. This is Adjustment Disorders, correct?
A. Uh-huh.
Q. Okay. And you see 309.28?
A. Let me see it.
Q. Okay. Well, you can certainly read it to the jury.
A. The important part about adjustment disorder --

Q. No, no, no. I'm asking the questions.
A. Okay.
Q. Okay. So it's 309.28. I can take it back because --
A. Sure.
Q. With all due respect. It says "Adjustment disorder with mixed anxiety and depressed mood," correct?
A. That's correct.
Q. Okay. And you'd agree with me that it also says, "A combination of depression and anxiety is predominant," right?
A. It's true, that does say that.
Q. So first and foremost, I understand that it's your opinion that Mrs. Irwin had some prior concussions prior to August 5, 2012, right? You know that, right?
A. I'm aware.
Q. Okay. And it's your opinion that none of her symptoms that existed, for instance, in February of 2012 are related to those earlier concussions, right?
A. Both my opinion and reflected in the medical records.
Q. Right, right, but you'd agree with me that people suffer from depression and anxiety when they don't have a brain injury, when they don't have trauma to the brain, right?
A. They can, yes.
Q. Okay. I mean, unfortunately, you know, some people's lives, they're tough, and they have difficult situations, and they have problems, right?

A. Yes.
Q. Right. It has nothing to do with a brain injury at all, right?
A. Yes, that is true.
Q. So, for instance, you would agree with me that Mrs. Irwin had depression and anxiety problems that were related to problems in her life at that particular time; namely, being married to a person who was abusive and an alcoholic, to having three children under five and not a very supportive husband, to having a job that was overwhelming? You'd agree with me, right?
A. There's some piece I would agree with that, and then the other piece I couldn't agree with.
Q. Okay, I got carried away.
A. You did, you did.
Q. I'll come back to it.
A. Okay.
Q. All right, so, like, an adjustment disorder can be over a particular event, right?
A. An adjustment disorder is generally considered over a short period of time, not a chronic thing, which is the important part to realize about adjustment disorder.
Q. All right. And at some point, if an adjustment disorder goes longer than six months and you have depression and anxiety continuing, then it becomes another type of disorder; like, for

instance, a major depressive disorder or something like that, right?

A. Well said, yes.

Q. Okay. So in this particular case, the Diagnostic -- you agree, the DSM-V is basically the bible of mental disorders, the manual of mental disorders, right?

A. I'm questioning the term "bible," but it is a resource for that information. That 309.28 is actually the ICD-9 code for it.

Q. Okay. And would you agree with me, "The presence of emotional or behavioral symptoms in response to an identifiable stressor is the essential feature of an adjustment disorder," correct?

A. That's correct.

Q. "And the stressor may be a single event," and it gives an example, a termination of a romantic relationship, "or there may be multiple stressors, marked business difficulties and marital problems." Do you agree with that?

A. That's correct, and that's noted here in this note.

Q. And you would agree with me that when someone has an adjustment disorder like 309.28 with mixed anxiety and depressed mood, that the symptoms related to that adjustment disorder are anxiety and also depression, correct?

MR. CHARNAS: Objection, your Honor, asked and answered.

THE COURT: Overruled.
Q. Do you want me to repeat the question?
A. I think I understood it.
Q. Do you agree with that?
A. That's correct.
Q. Now, if you could go back to my little list of the twelve, please. Thank you. So put down 3, feeling of being foggy; 4, irritability.
Do you think irritability and anger is pretty synonymous, Doctor, or are they different?
A. No, they're not the same.
Q. Let's go to fatigue and tiredness. Again, you would agree with me that there are medical records that exist prior to August 5, 2012, that essentially state that Mrs. Irwin was suffering from extensive fatigue, correct?
A. I'm not sure the word "extensive" is correct, but there are individual instances in the records when Ms. Irwin was sick that she noted that she had also a symptom of fatigue.
Q. Okay. One moment, please. Now, I'll come back to that in a second. The next one, difficulty with organization and planning, are you aware that Mrs. Irwin complained to Dr. Sontz that she was overwhelmed by the stressors in her life to include her job and taking care of her three children under five? Are you aware of that?
A. I'm aware of that. That was in the records, yes.

Q. Okay. Did you question Mrs. Irwin about that?
A. We talked about how she was -- although those things were hard, that she was managing all those things well and winning awards at Shire, as I mention in my report here.
Q. Okay, the next one is easily overwhelmed. Anxiety, but we already covered anxiety. Easily overwhelmed, are you aware that Dr. Sontz's records indicate on several occasions that Mrs. Irwin complained that her life was overwhelming? Are you aware of that?
A. I'm aware of that.
Q. So you would agree with me that that was a symptom that was in existence prior to August 5, 2012, correct?
A. But not immediately prior to August 5, 2012.
Q. Okay. The next one, sensitivity to light and noise, right? I read that correctly, right?
A. Yes.
Q. Okay. Now, when we talk about sensitivity to light, what's the fancy word for it, photophobia?
A. Photophobia, and sensitivity to noise is phonophobia.
Q. So photophobia means that you're sensitive to light. Does it include not only the light here in the building but also the sun? Does it include that?
A. Yes.
Q. Okay. Did Mrs. Irwin complain to you that she was sensitive to both internal lights and also the sun?

A. I didn't ask her specifically.
Q. Okay, so you just learned that she was sensitive to light?
A. That's correct.
Q. Okay. Now, the next one is frustration over not recovering it, and then the next one which I want to talk about more at length is difficulty with word finding, okay? Now, did you test Mrs. Irwin to see whether or not she had difficulty with word finding?
A. Yes.
Q. Okay. And you found out she had some difficulty, right?
A. On examination, she did, yes.
Q. Okay, would you agree with me that the recent records indicate that Mrs. Irwin's problems with word finding have been pretty much eliminated? Do you know that?
A. You mean with the current treatments that she's having?
Q. No, whether it's the current treatment or whatever, do you know whether or not Mrs. Irwin still has word-finding problems today?
A. I have not examined her again since then.
Q. Okay, but it's your opinion today before this jury that Mrs. Irwin has word-finding problems, right?
A. Yes.
Q. Okay. Were you here yesterday when Mrs. Irwin testified?
A. I was not here.
Q. Okay, you were in Boston, were you?

A. No. I arrived here last night.
Q. Okay. Would you agree with me -- well, first of all, let me represent to you that Mrs. Irwin testified yesterday for about five hours, okay? Are you aware of that?
A. No.
Q. Okay. Would you agree with me that the ladies and gentlemen of the jury who observed her testify yesterday would be good judges of whether or not she had word-finding problems?
A. No.
Q. You don't?
A. I don't know the professions of the folks here, but you certainly could have word-finding difficulties that would not be obvious unless tested upon.
Q. So if someone takes the stand and articulates in great detail about their profession and what they did, and how they met doctors and how they knew about renal disease and all that, you don't think the ladies and gentlemen of the jury are capable of judging her ability to do that?
A. I have a famous patient right now who will be on TV on many evenings in New York City, and he can speak and he can do well when you speak with him. On testing, he clearly has word-finding difficulties when he's in to be examined by me. With that said, I think that it would be my professional opinion that they would not necessarily know if she had word-finding difficulties or not. You need a medical

professional to look at that.
Q. Well, you think the ladies and gentlemen of the jury are capable of evaluating how someone responds to questions, whether they understand the question and give an answer?
A. I -- they may be able to, yes.
Q. They may be able to? Well, let me ask you this: If I ask you a question and I say to you, "What is your name?" right, and you answer "Brian Greenwald," don't you think that they're able to evaluate that and to see whether or not you answered it in an appropriate manner other than saying, like, you know, whatever, I mean, right?
A. I think it depends on the complexity of the questions that you're asking versus something simple like someone's name.
Q. Okay, No. 12, deviated nasal septum and recurrent sinus infection, are you aware that Mrs. Irwin suffered from sinusitis prior to August 5, 2012?
A. I am.
Q. Okay, you reviewed the medical records, correct?
A. I did.
Q. One moment, please. Now, would you agree with me, going back to this list -- and I know I jumped out of order a little bit, and I apologize for that -- feeling of being foggy, would that include not completing one's thoughts?
A. I don't believe that's what she was talking about when she said that she was feeling foggy.

Q. Okay, look at the --

MR. LAWLER: Can you bring up the record of the 12/29/11. I believe it's the exhibit of Dr. Lash. Could you focus on the middle of the document, please. Well, first of all, show the title to the doctor, please, so he knows what he's looking at. Thank you, thank you.

Q. Now, this particular record is -- I think we talked about fatigue -- December 29, 2011, correct?

A. Correct.

Q. Okay. And if you could go to the center of the document, please. And you can see it does refer to some sort of illness, but "Returned to work full time in November. Profound exhaustion is over the past one and a half weeks and hasn't been working during that time," and then right above it -- obviously it said "Returned to work full time in November" -- "Headache may be slightly better, but fatigue and lower throat discomfort are not."

You'd agree with me that she had some profound exhaustion for at least a week and a half that basically precluded her from going to work; is that right?

A. But you don't go down far enough to show the diagnosis was viral infection.

Q. Right.

MR. CHARNAS: Can we see the rest of the document on the screen, your Honor?

MR. LAWLER: You can see as much as you want, Counsel. Give him the whole document, please.

MR. CHARNAS: Thank you.

MR. LAWLER: Now, on July 24, 2012, could you pull that document up, please, as well. This is Exhibit 25-G, and the date is July 24, 2012, and you can show the whole document first to counsel to look at before I focus. Then could you focus on "History of present illness." Could you go down, please.

Q. Okay, so this is a document that essentially says that she's having worsening night vision and not sleeping much because of the three kids. Do you see that?

A. I see that.

Q. Okay. Would you agree with me that that's basically fatigue?

A. No.

Q. No?

A. I have a whole book on fatigue I could tell you about, but that's not fatigue.

Q. Okay, let me switch gears for a second here and see if we can talk about some other subject. I know on direct examination you talked about the fact that you know Mrs. Mary Hibbard, correct?

A. Dr. Hibbard.

Q. I'm sorry, Dr. Mary Hibbard. I apologize. It's getting

late in the day. And you and Dr. Hibbard know each other very well, right?
A. I haven't been to her apartment, but we worked together for about five years at Mount Sinai in the same department. I may have her cell phone number. That's about the extent of our knowing each other well.
Q. You would agree with me, for instance, when I deposed you, when I was asking you questions about her, you referred to her as Mary, right?
A. Correct.
Q. And you and Dr. Hibbard have worked on some cases together as expert witnesses, right?
A. I believe so.
Q. Okay. And in fact you got Dr. Hibbard involved in this particular case, right?
A. I was trying to remember. I don't recall specifically.
Q. Okay. Well, do you remember giving a deposition in this case?
A. That was like a whole year ago, so I probably remembered better then than I do now.
Q. But fortunately we have the transcript, so we can look at that testimony.
MR. LAWLER: Can I approach, your Honor?
A. I won't waste the jury's time. I wouldn't be surprised if I did get Dr. Hibbard involved with this case.

Q. Okay. And in addition there's another expert in this case, Dr. Benson, right?
A. That's correct.
Q. Okay. And Dr. Benson is going to testify tomorrow. Do you know that?
A. I'm aware of that.
Q. Okay, have you talked to Dr. Benson lately?
A. No.
Q. But you did refer this particular case to Dr. Benson, right?
A. That I'm sure I didn't do.
Q. You're sure you didn't do that?
A. I'm sure I didn't do that.
Q. Didn't you say that you sent these DTIs to get DTIs from Dr. Benson?
A. In this case specifically?
Q. Yes.
A. I did not. I did not recommend that Mr. Charnas use Dr. Benson.
Q. Okay. All right, so I want to get this straight. So you did not refer Mrs. Irwin directly to Dr. Benson, but you told Attorney Charnas, and at that particular time -- let me step back a little bit. At that particular time when you were retained as an expert, okay, you were an expert for Megan Irwin, right, Mrs. Irwin, right?

A. Correct.
Q. Okay. And you told Mr. Charnas about Dr. Benson?
A. I did not. I recommended that he get an MRI with diffusion tensor imaging, but I did not specifically recommend Dr. Benson.
Q. Are you positive about that?
A. 98.2 percent.
Q. But you and Dr. Benson, you know each other because you have spoken together at brain injury conferences, right?
A. I met Dr. Benson before.
Q. Well, isn't it true that, I think just recently, maybe the last year, that you and Dr. Benson spoke together at a brain injury conference in New Orleans before a bunch of lawyers?
A. I know that we were both on the list of people who spoke there. I wouldn't say that we spoke together. I think there was a whole panel of people who spoke, and I spoke and he spoke at that same conference, and that was one of the opportunities where I did meet him.
Q. Well, not only did you speak, you also listened to what Dr. Benson had to say, right?
A. I did stay to listen to his lecture.
Q. Have you referred other cases, other legal cases to Dr. Benson? You're saying you didn't refer this one. I understand your testimony, but have you referred any other medical legal cases to Dr. Benson?

A. Dr. Benson is in Detroit, which is far from New Jersey. So Dr. Benson is a good clinician, but it wouldn't be a common thing for me to refer people there. I know I've worked on cases where Dr. Benson has been an expert, but I can't think of even one case where I was the person who referred the person to him.

Q. Okay. Do you know another expert by the name of Dr. Ziejewski?

A. I do.

Q. Okay, I think I butchered his pronunciation. How do you pronounce his name?

A. I usually call him Mariusz because I have the same trouble as yourself.

Q. Okay. So are you aware that he's an expert in this particular case?

A. No, I'm not.

Q. You didn't get him involved in this particular case?

A. As I said, I didn't even know that he was an expert in the case.

Q. Let's talk a little bit about headaches. Are headaches something that you can -- just a regular headache, is it something that you can somehow locate with an objective test?

A. Can you locate the cause, or actually can you locate if the person is having pain or not?

Q. Well, let me simplify it. If I come to you and you're my

physiatrist, and I say to you, "I have a headache," first of all, do you believe me that I have a headache?
A. Do I believe you that you have a headache?
Q. Right.
A. I guess the physician/patient relationship is generally about people coming in and having their complaints. It's not necessarily about disbelieving them.
Q. Yes, I understand that, and that's in the typical, you know, patient/doctor relationship. So if I'm --
A. That's the scenario you gave me.
Q. Okay, and that's what I'm going to build on, the scenario, by the way.
A. Great.
Q. So if it's patient/doctor relationship, and I come in and I say, "I have a headache," you believe me, right?
A. Well, I don't disbelieve you.
Q. Okay. And then you typically say, "Okay, John Lawler, what's your headache, 0 to 10," right?
A. That would be a common thing to do.
Q. Okay. And I say I have a headache, it's a 7, it's really pounding and I've got a bad headache, and you believe me, right?
A. I still believe you.
Q. Okay. Now, change the scenario, and suddenly I'm involved in a lawsuit and it's a medical legal case, and there's more at

stake than just a cure, right?
A. Potentially, yes.
Q. Okay. So, first of all, someone can tell you that they have a headache when they really don't have a headache, right?
A. That could happen.
Q. And someone could tell you that they have a severe headache when they only have a mild headache, right?
A. That could happen.
Q. Okay, so headaches are basically subjective, right?
A. Are headaches subjective? The impairments from headaches are objective, but the headaches, certainly the intensity of a headache or having a headache or not is subjective.
Q. And when someone has a headache, what you typically do is, you want them to -- or a series of headaches, what you want them to do is complete a headache diary, right?
A. That's one of the things that can be helpful in monitoring the frequency of their headaches.
Q. To figure out what's causing them, how often they exist for, what gets rid of them, whether it's ibuprofen or Bayer Aspirin, right?
A. Yes.
Q. Okay. And are there also, for instance, like, for instance, as a physiatrist, do you go through, you know, headache regimes to try to get rid of a person who has headaches?

A. Well, the first thing you always do when someone comes in and has complaints of headache is to take a comprehensive history and physical examination to look at the type of headache it is. Headache is sort of a bigger class of problems, but there are different types of headaches. And then to make a more specific diagnosis on both where the headache is coming from, the type of headache that it is, and that will help sort of guide what treatment would be best for that person.

Q. Okay. And sometimes, if someone goes through a headache regimen, they can get rid of their headaches, right?

A. Sometimes, yes.

Q. Okay, I want to switch gears here a little bit. If you could turn to your report --

THE COURT: Mr. Lawler, are you switching to a topic of five minutes or less?

MR. LAWLER: No. It's probably a ten-minute topic.

THE COURT: All right, why don't we call it a day and continue tomorrow.

MR. LAWLER: That's fine. I think I have probably half an hour.

THE CLERK: All rise for the jury.

THE COURT: Keep an open mind, no talking, try to be on time tomorrow.

(Jury excused.)

THE COURT: He has a half an hour with him, let's say fifteen minutes for redirect and recross, something like that. That gets us to quarter of 11:00. Hibbard comes back on quarter of 11:00?

MR. LAWLER: That gets us to lunch.

THE COURT: That gets us to lunch.

MR. CHARNAS: How long do you have with Hibbard?

MR. LAWLER: Oh, I have easily an hour, I think.

THE COURT: Quarter of 11:00, quarter of 12:00, we'll have a break, so 12:15, maybe a little bit more. We can break for lunch somewhere in there. And then?

MR. CHARNAS: Dr. Benson.

THE COURT: How long with Benson? Benson will be on and off tomorrow?

MR. CHARNAS: Benson will definitely be on and off tomorrow, unless he cross-examines for an hour and a half or so, but, yeah, I'm sure he'll be on and off tomorrow.

THE COURT: Okay. So anything else we can accomplish today?

MR. CHARNAS: I don't think so, Judge.

THE COURT: Okay, I'll see you at quarter of 10:00 tomorrow.

MR. LAWLER: Thank you, your Honor.

(Adjourned, 3:58 p.m.)

C E R T I F I C A T E

UNITED STATES DISTRICT COURT)
DISTRICT OF MASSACHUSETTS) ss.
CITY OF BOSTON)

I, Lee A. Marzilli, Official Federal Court Reporter, do hereby certify that the foregoing transcript, Part 2, Pages 1 through 92 inclusive, was recorded by me stenographically at the time and place aforesaid in Civil Action No. 13-10974-ADB, Megan C. Irwin v. Eclectic Dining, Inc., and thereafter by me reduced to typewriting and is a true and accurate record of the proceedings.

Dated this 1st day of June, 2016.

/s/ Lee A. Marzilli
_____
LEE A. MARZILLI, CRR
OFFICIAL COURT REPORTER